

Primary care residency programs are regularly evaluating more cost-effective training models as they look towards expanding their resident complement to meet the increasing physician demand. Clinical training expenses in the outpatient environment represent the single largest; but manageable variable for teaching hospitals and faculty practice plans. Historically, a significant percentage of primary care residency training occurred through complex academic health systems that offered ambulatory training in hospital-operated clinics. These programs are frequently challenged to meet ambulatory training requirements for residents and should be designed using a primary care provider metrics model. Instead, they focus on supporting their higher-end fellowships. These limitations often result in residents being challenged to meet required patient volumes and unprepared for the rigors of private practice. Structuring ambulatory training to meet ACGME requirements for residency programs, drive optimal volume levels, and establish safe preceptor-resident ratios is critical to operating a high-performing continuity clinic and producing well-rounded PCPs.

New primary care demands, coupled with less traditional program sponsors such as community hospitals and FQHCs, have elevated the need for more cost-efficient training models. Many extenuating factors will dictate the degree of financial performance, not the least of which is the payor mix of the patient panel. Given that the resident clinic often has a high percentage of uninsured or underinsured patients, mitigating the required subsidy is a priority.

In comparison to traditional private practices, the complexities of teaching clinics present a unique set of challenges. Conventional medical practice management metrics are relevant to teaching clinics, but additional tools and approaches are required to address the added complexity of resident training. Academic Consulting Advisors (ACA) have identified five key variables that should be considered.

FACULTY EFFORT

Isolating and differentiating the faculty time spent in private practice, teaching clinics, and other responsibilities such as inpatient service or call coverage is critical to establishing baseline requirements. With the use of faculty and resident schedules, scheduling/billing information, and medical records data, required faculty time and effort can be accurately tracked, imputed, and subsequently managed to meet the primary care exemption ratios. Such differentiation will also ensure appropriate faculty time is dedicated to training while mitigating unnecessary faculty training time.

LEVERAGING THE PRIMARY CARE EXCEPTION (PCE)

Residents can provide care without direct supervision for moderate to low-level encounters in an ambulatory setting. Scheduling to ensure the PCE is effectively applied is necessary to optimize throughput and clinical performance. And the exception enables faculty members to precept up to four residents at a time; however, the best practice is to maintain a resident-to-faculty ratio of 3:1. This ratio needs to be actively managed to maintain productivity, patient safety, and curriculum standards.

PREDICTIVE SCHEDULING

In the ambulatory setting, for many specialties, the ACGME has shifted away from the required half-day sessions to a standard minimum number of weeks or patient visits during each year of the educational program; this shift fits nicely into a 4 + 1 block scheduling model. In this model, trainees do not simultaneously attend to inpatient and outpatient responsibilities. Instead, they spend four weeks on inpatient rotations and one week dedicated exclusively to the clinic. Such a model optimizes performance by focusing resident effort and eliminates the operational challenges of transitioning from inpatient to outpatient care on the same day. This model promotes effective management of the clinic and will optimize the productivity of each session while meeting training requirements.

MONITORING OF ACUITY LEVELS

Faculty must be physically present in the room with patients (and document accordingly) when a level 4 or 5 patient encounter is billed. Many resident clinics may default to level 3 or below to reduce potential audit risk or to allow residents to see the patient without the need for the attending physician to be present in the exam room. Active management through education and regular monitoring often shifts the E&M curve to more appropriate and realistic levels while achieving regulatory compliance.

TRACKING CLINICAL REQUIREMENTS

Many primary care residents have specific patient visits, procedural targets, and population diversity required by the ACGME. This is often manually tracked and managed, causing many programs to scramble to meet volume requirements before graduation. Integrating various software systems (e.g., billing, scheduling, medical records) can provide automated documentation of resident volumes and expeditiously compile the specific services, diversity, and procedures required to monitor program quality.

Although many concepts and variables introduced above are generally well-known and recognized in the academic community, these metrics, models, and tools specific to teaching environments are usually outside the focus of clinic operations. However, when the operating

parameters unique to the teaching setting are acknowledged and managed, the productivity potential dramatically increases and helps to produce practice-ready graduates.

An exceptional outpatient teaching experience can include operational efficiencies while simultaneously complying with the accreditation requirements set forth by the ACGME, leading to an overall enhanced program quality. Structuring clinic operations based on these variables will improve the overall financial viability of the clinic, provide a vehicle to improve access to the medically underserved community, and develop efficient practice-prepared physicians.

At ACA we work with our clients to evaluate program performance throughout the spectrum of the resident training experience. Our tailored recommendations support the alignment of academic performance goals for stakeholders, including; financial management, resource allocation, and organizational structure. Managing these academic variables is essential to maintaining viable teaching programs and ensuring their continued success.



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